MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10933 10939

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: 75 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Cambridge-Maryland Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
d. STREET ADDRESS: 409 High street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Davis — Last: Abbott

4. DATE OF DEATH: Month: Aug. — Day: 22, — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 5, 1881

9. AGE (In years last birthday): 86 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Hardware store employee

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Gray's Is., Dorchester Co., U.S.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Samuel J. Abbott

14. MOTHER'S MAIDEN NAME: Cilistine Langrall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 214-07-7925

17. INFORMANT: Mrs. Eleen V. Abbott, Address 409 High street, Cambridge, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 2 days

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ARTERIOSCLEROSIS

19. WAS AUTOPSY PERFORMED? YES ☐ ND ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/20, 1967, to 8/22, 1967, that (I) (we) last saw the deceased alive on 8/22 1967, and that death occurred at 3:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Alfred R. Maryanov M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/23/67

22c. PHYSICIAN'S NAME (Type): ALFRED R. MARYANOV

22d. ADDRESS: 610 RACE ST, CAMBRIDGE MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 24, 1967

23c. NAME OF CEMETERY OR CREMATORY: Green Lawn Cemetery

23d. LOCATION (City, town or county) (State): Cambridge, Md.

24. FUNERAL DIRECTOR: Kenneth R. Thomas — ADDRESS: Cambridge, Md.

25a. REC'D BY REGISTRAR DATE: AUG 25 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judges

VR A15 (4) 20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10940 **CERTIFICATE OF DEATH** 10940

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: 3 days, 17 hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Eastern Shore State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Queen Anne
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Grasonville, Md. 21638
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jacob — Middle: Byard — Last: Baker

4. DATE OF DEATH: Month: 8 — Day: 12 — Year: 19 67

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 12-18-1870

9. AGE (In years last birthday): 96 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gen. Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: General Contractor + Builder

11. BIRTHPLACE (County & State, or foreign country): Delaware,

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Isaac Baker

14. MOTHER'S MAIDEN NAME: Amanda Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 218-12-1476

17. INFORMANT — Address: Hospital admission Record.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS
DUE TO
(b): CEREBRAL VASCULAR INSUFFICIENCY — 2 DAYS
DUE TO
(c): CACHEXIA. — 3+ YRS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

355X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CHRONIC PANCREATITIS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from AUG 11, 1967, to AUG 12, 1967, that (I) (we) last saw the deceased alive on AUG 12 1967, and that death occurred at 6:45 A M, from causes and on the date stated above.

22a. SIGNATURE: Sean M Killoran — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Aug 12, 1967

22c. PHYSICIAN'S NAME (Type): SEAN M. KILLORAN

22d. ADDRESS: 7415 BLAIR RD. WASHINGTON D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: August 14, 1967

23c. NAME OF CEMETERY OR CREMATORY: Grasonville Cemetery

23d. LOCATION (City or Town) (County) (State): Grasonville Q.A.Co. Md.

24. FUNERAL DIRECTOR: James H Baxter & Sons — ADDRESS: Centreville Md

25a. REC'D BY REGISTRAR DATE: AUG 15 1967

25b. REGISTRAR'S SIGNATURE: [illegible] Judge

W.F.M.

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10941 (Reg. Dist. No.) 10941

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: 2 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Cambridge-Maryland Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Princess Anne R.F.D.#3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George — Middle W. — Last Barnes

4. DATE OF DEATH: Month August — Day 15, — Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 4-16-16

9. AGE (In years last birthday): 51 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mrs. Helen Barnes; Route #3, Princess Anne

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
4201
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Alfred R. Maryanov M.D.
EXAMINER'S NAME (Type): Alfred R. Maryanov
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: August 15, 1967

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/17
22c. NAME OF CEMETERY OR CREMATORY: Beechwood Memorial
22d. LOCATION (City, town, or county) (State): Princess Anne, Somerset Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James Hannum
ADDRESS: Princess Anne, Md.
24a. REC'D BY REGISTRAR DATE: AUG 21 1967
24b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10942

CERTIFICATE OF DEATH

10942

1. PLACE OF DEATH
a. COUNTY: DORCHESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMBRIDGE (RURAL)
c. LENGTH OF STAY IN 1b: 35 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): EASTERN SHORE STATE HOSPITAL

2. USUAL RESIDENCE (Where deceosed lived, if institutian: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Caroline — QUEEN ANNE
c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town): MARYDEL
d. STREET ADDRESS: 052
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type ar print): First ESTELLE — Middle MAUDE — Lost BOSELY

4. DATE OF DEATH: Month AUGUST — Day 30 — Year 19 67

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 01-12-88

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind af wark dane during mast af working life, even if retired): HOUSEWORK

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: JOHN W BOSELY

14. MOTHER'S MAIDEN NAME: MARTHA JANE SLAUGHTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dotes of service):

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT Address: RECORDS OF THE EASTERN SHORE STATE HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter anly one couse per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): senile cadexia -
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.
300.3
INTERVAL BETWEEN ONSET AND DEATH: months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Schizophrenia - Paranoid -

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Manth, Day, Year — Hour o.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Nat While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased olive on _____ 19____, and that death occurred at _____ M, from causes and on the date stated above.

22a. SIGNATURE: Felipe R. Dominguez M.D.
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): FELIPE DOMINGUEZ M. D.

22d. ADDRESS: EASTERN SHORE STATE HOSPITAL

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-3-67

23c. NAME OF CEMETERY OR CREMATORY: Templeville

23d. LOCATION (City or Town) (County) (State): Templeville, Md.

24. FUNERAL DIRECTOR ADDRESS: J. E. Boulais Greensboro, Md.

25a. REC'D BY REGISTRAR DATE: SEP 6 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral directar. Page 4 should be forwarded to the Chief Medicol Exominer's Office along with farm PM3. Page 5 may be retoined for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as o burial-tronsit permit. File pages 1 and 2 with the State Department of Health prior to buriol, cremation, or removol, and in any event within 72 hours ofter deoth.

VR A15ME (6) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10943

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10943

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. Cambridge Md. Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
09-1
d. STREET ADDRESS: 923 Phillips St. Ext.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

99

I

3. NAME OF DECEASED (Type or print): First: John; Middle: Henson; Last: Bowley
4. DATE OF DEATH: Month: August; Day: 12; Year: 19 67

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9/10/1884
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Bowley
14. MOTHER'S MAIDEN NAME: Harriet Spicer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 219-70-7842
17. INFORMANT: Agnes Pinder; Address: Cambridge, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: ?
331 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Mace Jr. M.D.
EXAMINER'S NAME (Type): John Mace Jr.MD.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: 8/21/67
Address (Street, city, town, or county): Cambridge, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/15/67
23c. NAME OF CEMETERY OR CREMATORY: Bethel Cemetery
23d. LOCATION (City or Town) (County) (State): Cambridge, Dor. Md.

24. FUNERAL DIRECTOR: StClair Funeral Directors — ADDRESS: Cambridge, Md.
25a. REC'D BY REGISTRAR — DATE: AUG 22 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Yeager

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10944 10944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: 3 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glasglow Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico ~~Dorchester~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Crocheron~~ Eden
d. STREET ADDRESS: Rt
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ida — Middle: LEMON — Last: Brittingham

4. DATE OF DEATH: Month: August — Day: 20 — Year: 19 67

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: October 16, 1880

9. AGE (In years last birthday): 86 yrs. — IF UNDER 1 YEAR: Months: 10 — Days: 4 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Crocheron, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William H. Todd

14. MOTHER'S MAIDEN NAME: Melvinia Bramble

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mr. James McNamara (Son) 305 Annapolis St., Annapolis, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: RECENT

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — YEARS

DUE TO (c): HYPERTENSION — YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): N/A

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-20, 1967, to 8-20, 1967, that (I) (we) last saw the deceased alive on 8-20 1967, and that death occurred at 7:25 P.M., from the causes and on the date stated above.

22a. SIGNATURE: James F. McCarter M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8-20-67

22c. PHYSICIAN'S NAME (Type): JAMES F. McCARTER, M.D.

22d. ADDRESS: BOX 386 CAMBRIDGE, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: August 23, 1967

23c. NAME OF CEMETERY OR CREMATORY: St. John's Cemetery

23d. LOCATION (City, town or county) (State): Fruitland, Maryland

24. FUNERAL DIRECTOR — ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR DATE: AUG 22 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, crematian, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10945

CERTIFICATE OF DEATH

10945

1. PLACE OF DEATH
a. COUNTY: DORCHESTER
EASTERN SHORE STATE HOSPITAL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest tawn): RURAL CAMBRIDGE
c. LENGTH OF STAY IN 1b: 9 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspitol, give street address): EASTERN SHORE STATE HOSPITAL

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside carparate limits, write RURAL and give neorest tawn): 783 FITZWATER ST., SALISBURY
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First SEAMORE — Middle — Lost BROWN
4. DATE OF DEATH: Manth AUG. 4 — Doy — Year 1967
5. SEX: MALE
6. COLOR OR RACE: NEGRO
7. MARRIED ☐ NEVER MARRIED ☐ SEPARATED WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/4/90
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Manths / Doys
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of warking life, even if retired): LABORER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (Caunty & Stote, or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: NATHANIEL BROWN
14. MOTHER'S MAIDEN NAME: ALICE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) –
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 217-10-3524A
17. INFORMANT: HOSPITAL RECORDS — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter anly one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 491X Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 Days
DUE TO (b): Senil cachexia — 1 year
Conditions, if ony, which gave rise to immediate couse (a), stoting the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypochromic anemia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Manth, Doy, Yeor Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or tawn) (County) (State)

21. **I certify** that (I) (this haspital) attended the deceased from July 26, 1967, to August 4, 1967, that (I) (we) last saw the deceased alive an August 4 1967, and that death accurred at 8:35 AM, fram causes and an the date stated abave.

22a. SIGNATURE: Carlos F Barroso — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑
22b. DATE SIGNED: 8-4-67
22c. PHYSICIAN'S NAME (Type): CARLOS F. BARROSO
22d. ADDRESS: Hurlock Dorchester Co Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/9/67
23c. NAME OF CEMETERY OR CREMATORY: Green Acres Cemetery
23d. LOCATION (City or Town) (County) (State): Salisbury Wicomico Md

24. FUNERAL DIRECTOR: Clinton F Stewart — ADDRESS: Wat Road Salisbury, Md
25a. REC'D BY REGISTRAR DATE: AUG 8 1967
25b. REGISTRAR'S SIGNATURE: Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10946 **CERTIFICATE OF DEATH** 10946

1. **PLACE OF DEATH**
a. COUNTY: DORCHESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL CAMBRIDGE
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): EASTERN SHORE STATE HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: KENT
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): CHESTERTOWN
d. STREET ADDRESS: R.F.D.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First SAMUEL — Middle IRVING — Last CHANCE

4. **DATE OF DEATH**: Month AUGUST — Day 4 — Year 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 9/25/94

9. AGE (In years last birthday): 72 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of wark dane during most of working life, even if retired): CARPENTER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Queen anne Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WALTER NATHANIEL CHANCE

14. MOTHER'S MAIDEN NAME: LILLIAN ELIZABETH ELLERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, ar unknown): - no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 181-05-7793A

17. **INFORMANT** Address: HOSPITAL RECORDS

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter anly one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): Arteriosclerosis and hypertension — 1 year
DUE TO (c):
Conditions, if ony, which gave rise to immediate cause (a), stoting the underlying cause last.
331/X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I ar Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 30, 1967, to August 4, 1967, that (I) (we) last saw the deceased alive an August 4 1967, and that death accurred at 2:02 p M, fram causes and an the date stated abave.

22a. SIGNATURE: Carlos F Barroso M.D. — ATTENDING PHYS. ☐ — MED. DIRECTOR ☐ — STAFF PHYS. ☑

22b. DATE SIGNED: 8/4/67

22c. PHYSICIAN'S NAME (Type): CARLOS F. BARROSO

22d. ADDRESS: E.S.S.HOSPITAL, CAMBRIDGE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/6/67

23c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel Cem.

23d. LOCATION (City or Town) (County) (State): Rock Hall, Md.

24. FUNERAL DIRECTOR: J. Willis Wells — ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE AUG 7 1967

25b. REGISTRAR'S SIGNATURE: Frances Jones

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10947 10947

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hurlock
c. LENGTH OF STAY IN 1b: 4 yrs. 21 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Belle Haven Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsburg
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CELIA Middle MARTIN Last COULBOURNE

4. DATE OF DEATH: Month August Day 21 Year 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: February 23, 1868

9. AGE (In years last birthday): 99 yrs. IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Dorchester Co., Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William J. Hurlock

14. MOTHER'S MAIDEN NAME: Mahalia Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: ---

17. INFORMANT Address: Betty C. Williamson, Williamsburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Senile Cachexia — INTERVAL BETWEEN ONSET AND DEATH: 1 year
794X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-4-66, 19__ to 8-21, 19 67, that (I) (we) last saw the deceased alive on August 21 19 67, and that death occurred at 8:10 AM, from the causes and on the date stated above.

22a. SIGNATURE: C. Alfs F Barroso M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8-21-67

22c. PHYSICIAN'S NAME (Type): CARLUS F BARROSO

22d. ADDRESS: Hurlock Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 24, 1967

23c. NAME OF CEMETERY OR CREMATORY: Hill Crest Cemetery

23d. LOCATION (City, town or county) (State): Federalsburg, Maryland

24. FUNERAL DIRECTOR: Jerome Frampton Jr. ADDRESS: J. J. Frampton and Son, Federalsburg, Maryland

25a. REC'D BY REGISTRAR DATE: AUG 30 1967

25b. REGISTRAR'S SIGNATURE: Charles Yingst

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10948 10948

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
   a. COUNTY: Dorchester — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Cambridge
   c. LENGTH OF STAY IN 1b: 5yrs. 1Mon. 11days.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Eastern Shore State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Md. — b. COUNTY: Talbot
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tilghman
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First Harriett — Middle P. — Last Covington

4. **DATE OF DEATH**: Month 08 — Day 19 — Year 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11-30-88

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry Kinnamon

14. MOTHER'S MAIDEN NAME: Harriett Duncan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 214-12-6014

17. **INFORMANT** Med Records Address: Eastern Shore State Hospital

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5 HRS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
4500

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome, Uremia, Pneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that ~~I~~ (this hospital) attended the deceased from 7-2-, 1962 to 8-19-, 1967 that (I) ~~(we)~~ last saw the deceased alive an 8-19- 1967 and that death occurred at 8:30 M, from causes and on the date stated above

22a. SIGNATURE: E Lewis — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 8-19-67

22c. PHYSICIAN'S NAME (Type): EDWARD LEWIS JR

22d. ADDRESS: ESSH, CAMBRIDGE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 8/22/1967

23c. NAME OF CEMETERY OR CREMATORY: ST. JOHN'S

23d. LOCATION (City or Town) (County) (State): TILGHMAN, MD

24. FUNERAL DIRECTOR: Maurice E Williamson — ADDRESS: Easton, Md

25a. REC'D BY REGISTRAR DATE: AUG 23 1967

25b. REGISTRAR'S SIGNATURE: Charles Jones

2 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10949 10949

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: DORCHESTER — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest tawn): CAMBRIDGE (RURAL)
c. LENGTH OF STAY IN 1b: 2 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): EASTERN SHORE STA TE HOSPITAL

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): SALISBURY
d. STREET ADDRESS: 927 JOHNSON STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or pnnt): First MARY — Middle PRISCILLA — Lost COX
4. DATE OF DEATH: Month AUGUST — Doy 22 — Year 19 67

5. SEX: F FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 04-19-86
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months — Doys
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WAITRESS
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM AUSTIN
14. MOTHER'S MAIDEN NAME: JANE GIVANS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give wor or dates of service)
16. SOCIAL SECURITY NO.: 218-16-8023
17. INFORMANT: Mrs. Florence Hooper (Daughter) Address: RECORDS OF THE EASTERN SHORE STATE HOSPITAL 927 Johnson Street, Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 weeks
DUE TO (b): Chronic brain syndrome — 4 years
DUE TO (c): senility
493 X
Conditions, if ony, which gove rise to immediate cause (a), stoting the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.): N/A
20c. TIME OF INJURY Month, Doy, Yeor Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this haspital) attended the deceased from 06-04-65, 19__, to 08-22-67, 19__, that (I) (we) last saw the deceased alive on 08-22 19 67, and that death occurred at 8:20 P.M. from causes and an the date stated above.

22a. SIGNATURE: John Blair Webster M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: August 22, 1967
22c. PHYSICIAN'S NAME (Type): JOHN BLAIR WEBSTER M.D.
22d. ADDRESS: EASTERN SHORE STATE HOSPITAL

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: August 26, 1967
23c. NAME OF CEMETERY OR CREMATORY: Allen Cemetery
23d. LOCATION (City or Town) (County) (State): Allen, Maryland

24. FUNERAL DIRECTOR ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE: AUG 25 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

2 1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5M) 6M 1/67

10950

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10950

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Cambridge
c. LENGTH OF STAY IN 1b: 12 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): 211 East Appleby Ave.

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Cambridge, Md. 09.1
d. STREET ADDRESS: 211 E. Appleby Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Katie — Middle: Hurley — Lost: Dayton

4. DATE OF DEATH: Month: Aug. — Doy: 16, — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1/1/1882

9. AGE (In yeors last birthday): 85 yrs.

IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Levin H. Hurley

14. MOTHER'S MAIDEN NAME: Elizabeth Beard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Orville Dayton — Address: 211 E. Appleby Ave. Cambridge, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant
4201
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify thot I took chorge of the remoins described obove, held on Autopsy ☐, Inspection ☒, Inquiry ☐, ond in my opinion deoth resulted from: Notural couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: John Mace Jr M.D.
EXAMINER'S NAME (Type): John Mace Jr. M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: 8/17/67
Address (Street, city, town, or county): Cambridge, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/19/67
23c. NAME OF CEMETERY OR CREMATORY: Elloitt Cemetery
23d. LOCATION (City or Town) (County) (State): Dorchester Co., Md.

24. FUNERAL DIRECTOR ADDRESS: Willoughby Funeral Diredtor. East New Market Md.

25a. RECD BY REGISTRAR DATE: AUG 23 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10951 Item#23 FilmG392 8/24/67 hr 10951

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Dorchester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: All life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 801 Fairmount Ave.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge 09-1
d. STREET ADDRESS: 801 Fairmount Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Hansel Middle Last Green
4. DATE OF DEATH: Month August Day 4 Year 19 67

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-18-1908
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Motel owner
10b. KIND OF BUSINESS OR INDUSTRY: Motel & Bar
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Green
14. MOTHER'S MAIDEN NAME: ADA TRAVERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 220-32-9543
17. INFORMANT Address: Lena Green, Cambridge, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bullet wound chest — INTERVAL BETWEEN ONSET AND DEATH: 2 Min.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
976X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Shot self with pistol
20c. TIME OF INJURY Month, Day, Year Hour a.m.: 10.20AM 8/4/67 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Cambridge (County) Dor. (State) Md.

21. I certify that I taak charge af the remains described abave, held an Autapsy ☐, Inspectian ☐, Inquiry ☐, and in my apinian death resulted from: Natural causes ☐, Accident ☐, Suicide ☒ Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Mace Jr. M.D.
EXAMINER'S NAME (Type): John Mace Jr.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED: 8/6/67

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: 8/8/67
23c. NAME OF CEMETERY OR CREMATORY: Bethel
23d. LOCATION (City or Town) Cambridge (County) Dorchester (State) Md.

24. FUNERAL DIRECTOR: Fuller L West ADDRESS: Cambridge Md.
25a. RECD BY REGISTRAR DATE: AUG 8 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10952

CERTIFICATE OF DEATH

10952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: DORCHESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMBRIDGE
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): CAMBRIDGE MARYLAND HOSPITAL, INC.

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission)
a. STATE: MARYLAND
b. COUNTY: DORCHESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): CAMBRIDGE
d. STREET ADDRESS: 901 MACES LANE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HILUID; Middle VINCENT; Lost GREEN

4. DATE OF DEATH: Month AUGUST; Doy 12; Yeor 1967

5. SEX: MALE
6. COLOR OR RACE: NEGROID
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: MAR. 1, 1879
9. AGE (In yeors last birthdoy): 88 yrs.
IF UNDER 1 YEAR: Months; Doys
IF UNDER 24 HRS.: Hours; Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10b. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (County & Stote, or foreign country): DORCHESTER CO., MD.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: THOMAS GREEN
14. MOTHER'S MAIDEN NAME: ROSIE CAMPER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give wor or dotes of service): ----
16. SOCIAL SECURITY NO.: 214-07-8925A
17. INFORMANT: ADLEY GREEN — Address: CAMBRIDGE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Cardiac decompensation
DUE TO (b): hypertensive arteriosclerotic heart disease
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse last.
DUE TO (c):
443X
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (Stote)

21. I certify that (I) (this hospital) attended the deceased from July 17, 1967, to August 12, 1967 that (I) (we) last saw the deceased alive on August 12, 1967, and that death occurred at _____ M, from causes and on the date stated above.

22o. SIGNATURE: J. Edwin Fassett
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: August 13, 67
22c. PHYSICIAN'S NAME (Type): J. Edwin Fassett, M.D.
22d. ADDRESS: 623 High Street Cambridge, Md.

23o. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 8/16/67
23c. NAME OF CEMETERY OR CREMATORY: BETHEL
23d. LOCATION (City or Town) (County) (Stote): CAMBRIDGE DOR. MD.

24. FUNERAL DIRECTOR: Frederick C. Taylor
ADDRESS: CAMBRIDGE, MD.
25o. REC'D BY REGISTRAR DATE AUG 22 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jagger

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10953 — 10953

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
   a. COUNTY: Dorchester — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
   c. LENGTH OF STAY IN 1b: 1 week
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Cambridge Maryland Hospital

2. **USUAL RESIDENCE** (Where deceosed lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Dorchester
   c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Fishing Creek
   d. STREET ADDRESS: None
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First MATTIE — Middle PHILLIPS — Lost HANSEN

4. **DATE OF DEATH**: Month Aug. — Day 7, — Year 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: May 31, 1897

9. AGE (In years last birthday): 70 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Dorchester Co., Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John R. Phillips

14. MOTHER'S MAIDEN NAME: Ida Meekins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
   (If yes give wor or dotes of service): - - -

16. SOCIAL SECURITY NO.: 212-16-7075

17. **INFORMANT** — Address: Mrs. John Phillips, Fishing Creek, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 6 mos
   DUE TO (b): Carcinoma Sigmoid — 2 yrs
   DUE TO (c):
   Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse last.

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June, 1964 to Aug 7, 1964 that (I) (we) last saw the deceased alive on 8-7 1967, and that death occurred at 12:25 M, from causes and on the dotes stoted above.

22a. SIGNATURE: W Baumann M.D. — ATTENDING PHYS. ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 8-7-67

22c. PHYSICIAN'S NAME (Type): W. N. Baumann, MD

22d. ADDRESS: Franklin St., Cambridge, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug 9 1967

23c. NAME OF CEMETERY OR CREMATORY: Star Of Sea Cemetery

23d. LOCATION (City or Town) (County) (State): Golden Hill, Maryland

24. FUNERAL DIRECTOR — ADDRESS: LeCompte Funeral Service, Cambridge, Maryland

25a. REC'D BY REGISTRAR — DATE: AUG 11 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

7 1

10954 10954

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hurlock - Rural
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Bobtown

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Hurlock - Rural
d. STREET ADDRESS: Bobtown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PHILLIP; Middle LEON; Last HOLLIDAY

4. DATE OF DEATH: Month August; Doy 27; Year 1967

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 13,1914

9. AGE (In yeors lost birthdoy): 53 yrs.

IF UNDER 1 YEAR: Months; Doys
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Day Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Caroline Foods

11. BIRTHPLACE (County & Stote, or foreign country): Dorchester Co., Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William F. Camper

14. MOTHER'S MAIDEN NAME: Emma V. Holliday

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 214-30-8920

17. INFORMANT Address: Delsia M. Holliday, Hurlock, Md., RFD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Acute ventricular Dilatation cFibrillation sec
442X
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse last.
DUE TO (b): Arteriosclerotic Hypertensive Cardio
DUE TO (c): renal disease with failure — INTERVAL BETWEEN ONSET AND DEATH: 2yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 6/15, 1965, to 8/27/67, 19___, that (I) (we) last saw the deceased alive on 8/26/67 19___, and that death occurred at 4 A. M, from causes and on the date stated above.

22a. SIGNATURE: Harold B. Lummer — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/29/67

22c. PHYSICIAN'S NAME (Type): Harold B. Lummer M.D

22d. ADDRESS: Preston Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept.2,1967

23c. NAME OF CEMETERY OR CREMATORY: Federal Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Federalsburg, Maryland

24. FUNERAL DIRECTOR: J. J. Frampton Jr.

ADDRESS: Frampton and Son, Federalsburg, Maryland

25a. REC'D BY REGISTRAR DATE: AUG 31 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10955 10955

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Cambridge Maryland Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Madison
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HAMILTON — Middle - - — Last HORSEMAN, Sr

4. DATE OF DEATH: Month Aug. — Day 7, — Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 23, 1904

9. AGE (In years last birthday): 63 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance

10b. KIND OF BUSINESS OR INDUSTRY: County Roads

11. BIRTHPLACE (County & State, or foreign country): Dorchester Co., Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Winfield Horseman

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): - - -

16. SOCIAL SECURITY NO.: 217-10-8790

17. INFORMANT: Mrs. Hilda Horseman, Madison, Maryland — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hepatic Failure
DUE TO (b): Cirrhosis of Liver
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: Unk / ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19__, to 8/7, 19 67 that (I) (we) last saw the deceased alive on 8/7 19 67, and that death occurred at _____ M, from causes and on the date stated above.

22a. SIGNATURE: J. U. Thompson, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/8/67

22c. PHYSICIAN'S NAME (Type): J. U. Thompson, MD

22d. ADDRESS: Cambridge, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug 9, 1967

23c. NAME OF CEMETERY OR CREMATORY: Dorchester Memorial Park

23d. LOCATION (City or Town) (County) (State): Cambridge, Maryland

24. FUNERAL DIRECTOR: LeCompte Funeral Service, Cambridge, Maryland — ADDRESS

25a. REC'D BY REGISTRAR DATE: AUG 11 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10956

CERTIFICATE OF DEATH

10956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Cambridge Maryland Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Cambridge
d. STREET ADDRESS: RFD No. 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOHN — Middle LESLIE — Last HUBBARD

4. DATE OF DEATH: Month Aug. — Day 15, — Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 18, 1904

9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Gen. Building

11. BIRTHPLACE (County & State, or foreign country): Dorchester Co., Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Raymond Hubbard

14. MOTHER'S MAIDEN NAME: Foly Marshall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): - - -

16. SOCIAL SECURITY NO.: 213-05-2741

17. INFORMANT: Mrs. J. Leslie Hubbard, Address: RFD 3, Cambridge Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lymphosarcoma right lung with — INTERVAL BETWEEN ONSET AND DEATH: 7 months
DUE TO (b): metastases to mediastinum & cervical glands
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/11/67, 19__, to 8/15/67, 19__, that (I) (we) last saw the deceased alive on 8/15/67 19__, and that death occurred at 8:15 A.M. from causes and on the date stated above.

22a. SIGNATURE: Lawrence Maryanov — M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/17/67

22c. PHYSICIAN'S NAME (Type): Lawrence Maryanov

22d. ADDRESS: 610 Race St. Cambridge, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug 19 1967

23c. NAME OF CEMETERY OR CREMATORY: Spedden-Seward Cemetery

23d. LOCATION (City or Town) (County) (State): RFD 3, Cambridge, Maryland

24. FUNERAL DIRECTOR: LeCompte Funeral Service, Cambridge, Maryland
ADDRESS

25a. REC'D BY REGISTRAR
DATE: AUG 21 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10957

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10957

1. PLACE OF DEATH
   a. COUNTY: Dorchester — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
   c. LENGTH OF STAY IN 1b: 1 Hour
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Cambridge Maryland Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission)
   a. STATE: Maryland — b. COUNTY: Caroline
   c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Preston (Rural)
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIE — Middle — Last HUDSON JR.

4. DATE OF DEATH: Month August — Doy 23, — Year 19 67

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 5, 1940

9. AGE (In years lost birthdoy): 27 yrs.
   IF UNDER 1 YEAR: Months — Doys
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Day Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Factory

11. BIRTHPLACE (Stote or foreign country): Georgia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Willie Hudson

14. MOTHER'S MAIDEN NAME: Alice Morton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): No

16. SOCIAL SECURITY NO.: 255-60-5783

17. INFORMANT — Address: Willie Hudson Preston, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Multiple injuries, severe — INTERVAL BETWEEN ONSET AND DEATH: Instant
DUE TO
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
Driver of car in two car collision.

20c. TIME OF INJURY Month, Doy, Year — Hour o.m. p.m.: 1 AM 8/23/67

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.): Highway

20f. (City or town) (County) (Stote): Hurlock, Dor. Md.

21. **I certify** that I took chorge of the remains described obave, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinian death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Mace Jr. M.D.

EXAMINER'S NAME (Type): John Mace Jr.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 8/25/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 26, 1967

23c. NAME OF CEMETERY OR CREMATORY: Johns Cemetery

23d. LOCATION (City or Town) (County) (Stote): Preston Caroline Maryland

24. FUNERAL DIRECTOR — ADDRESS: Frampton Funeral Home-Federalsburg, Md.

25a. REC'D BY REGISTRAR: AUG 30 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10958 10958

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: DORCHESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMBRIDGE
c. LENGTH OF STAY IN 1b: 1yr. 5mo 18da
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): EASTERN SHORE STATE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: DORCHESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RHODES DALE
d. STREET ADDRESS: ~~R.F.D.~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First ADDIE — Middle — Last JONES

4. DATE OF DEATH: Month 8 — Day 5 — Year 19 67

5. SEX: 7.

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☑ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Feb. 9, 1883

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (County & State, or foreign country): DOR. MD. U.S.A

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: BENJAMIN JONES

14. MOTHER'S MAIDEN NAME: MARY A. COULBOURNE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 218-20-5335

17. INFORMANT — Address: HOSPITAL RECORDS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 4 DAYS
DUE TO
(b): GENERALIZED ARTERIOSCLEROSIS — 1½ YEARS
DUE TO
(c):
4500
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CHRONIC BRAIN SYNDROME

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ~~I~~ (this hospital) attended the deceased from 2-18-66, 19__ to 8-5-__, 1967, that (I) (~~we~~) last saw the deceased alive on 8-5-__ 1967, and that death occurred at 1130 AM, from causes and on the date stated above.

22a. SIGNATURE: Edwards — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 8-5-67

22c. PHYSICIAN'S NAME (Type): EDWARD LEWIS, JR., MD

22d. ADDRESS: ESSH - CAMBRIDGE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: Aug. 8, 1967

23c. NAME OF CEMETERY OR CREMATORY: Cokesbury Cemetery

23d. LOCATION (City or Town) (County) (State): Near Federalsburg Md.

24. FUNERAL DIRECTOR Frumptom Funeral Home — **ADDRESS**: Lexington Funeral Home Federalsburg Md.

25a. REC'D BY REGISTRAR DATE AUG 18 1967

25b. REGISTRAR'S SIGNATURE: Charles Jaggers

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10959 10959

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Dorchester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: 20 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 308 Talbot Ave.,

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
d. STREET ADDRESS: 308 Talbot Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Benjamin Middle Lost Kidan
4. DATE OF DEATH: Month August Day 16 Year 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct.18,1908
9. AGE (In years last birthday) yrs.: 58
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor of Sewing
10b. KIND OF BUSINESS OR INDUSTRY: Factory
11. BIRTHPLACE (State or foreign country): New York City
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Moses Kidan
14. MOTHER'S MAIDEN NAME: Flora Rosenberg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): W.W. 2
16. SOCIAL SECURITY NO.: 062-01-5692
17. INFORMANT: Address 308 Talbot Ave., Mrs. Marion J. Kidan, Cambridge, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carbon monoxide poison
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH: Instant

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Suicide by carbon monoxide in automobile
20c. TIME OF INJURY Month, Day, Year: Hour 8 a.m. AM p.m. 8-16 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): In auto-Home
20f. (City or town) Cambridge (County) Dor. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John Mace Jr. M.D.
EXAMINER'S NAME (Type): John Mace Jr.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 8/17/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug.18,1967
23c. NAME OF CEMETERY OR CREMATORY: Dorchester Memorial Park,
23d. LOCATION (City or Town) Cambridge, (County) (State) Md.

24. FUNERAL DIRECTOR: Kenneth R Stroud ADDRESS: Cambridge, Md.
25a. REC'D BY REGISTRAR DATE AUG 23 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMC Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10960 10960

CERTIFICATE OF DEATH

1. PLACE OF DEATH
   a. COUNTY: Dorchester
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cambridge
   c. LENGTH OF STAY IN 1b: 2 days
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Cambridge-Maryland Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland b. COUNTY: Dor.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): East New Market, Md. R.D. 09.1
   d. STREET ADDRESS: Rural Rt. 16
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Helen Middle: Virginia Last: Knaack

4. DATE OF DEATH: Month: Aug. Day: 27 Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Dec. 19, 1902

9. AGE (In years last birthday): 64 yrs.
   IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Talbot County

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Collison

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 216-40-3443

17. INFORMANT: Johnie E. Knaack, East New Market, Md. Address: R.D. 1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma Sigmoid — INTERVAL BETWEEN ONSET AND DEATH: 15 mos
153.3
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-20, 1966, to 8-27, 1967, that (I) (we) last saw the deceased alive on 8-27 1967, and that death occurred at 5:30 A. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 8-28-67

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 29, 1967

23c. NAME OF CEMETERY OR CREMATORY: Spring Hill Cemetery

23d. LOCATION (City, town or county) (State): Easton, Maryland

24. FUNERAL DIRECTOR: Kenneth R. Thomas ADDRESS: Cambridge, Md.

25a. REC'D BY REGISTRAR DATE: SEP 1 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

6:30 A.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10961

CERTIFICATE OF DEATH

10961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): East New Market
c. LENGTH OF STAY IN 1b: 1 Month
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): St. Steven's Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge, Md.
d. STREET ADDRESS: 721 Bailey Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sallie — Middle: Brown — Last: Larimore

4. DATE OF DEATH: Month: Aug — Day: 26 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 12, 1883

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Brown

14. MOTHER'S MAIDEN NAME: Sallie Larimore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: No

17. INFORMANT — Address: Le Compte Funeral Service, Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Ventricular Fibrillation with — INTERVAL BETWEEN ONSET AND DEATH: minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Left Ventricular Dilation, Arteriosclerotic
DUE TO (c): Heart disease with auricular Fibrillation 4yrs

4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/14, 19 67, to 8/26/67, 19 ___, that (I) (we) last saw the deceased alive on 8/24, 19 67, and that death occurred at ___ M, from the causes and on the date stated above.

22a. SIGNATURE: Harold B. Plummer M.D

M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/30/67

22c. PHYSICIAN'S NAME (Type): Harold B. Plummer M.D

22d. ADDRESS: Presston Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug 29, 1967

23c. NAME OF CEMETERY OR CREMATORY: Greenlawn Cemetery

23d. LOCATION (City, town or county) (State): Cambridge, Md.

24. FUNERAL DIRECTOR — ADDRESS: Le Compte Funeral Service, 308 High St, Cambridge, Md.

25a. REC'D BY REGISTRAR DATE: SEP 5 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10962 10962

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: DORCHESTER MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL CAMBRIDGE
c. LENGTH OF STAY IN 1b: 6 WEEKS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): EASTERN SHORE STATE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD. b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
d. STREET ADDRESS: 628 HILL ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BERTHA Middle BURNETT Last MILBOURNE

4. DATE OF DEATH: Month AUGUST Day 31 Year 1967

5. SEX: FEMALE
6. COLOR OR RACE: INDIAN
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11/19/90
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Burnett
14. MOTHER'S MAIDEN NAME: ELEANOR BURNETT Robinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 218-24-4319A
17. INFORMANT: HOSPITAL RECORDS Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(b): Senile cachexia — 1 year
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
490X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/16, 1967, to 8/31, 19 67 that (I) (we) last saw the deceased alive on 8/31 19 67, and that death occurred at 8:10 A.M. from causes and on the date stated above.

22a. SIGNATURE: Carlos F Barroso M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/31/67
22c. PHYSICIAN'S NAME (Type): CARLOS F BARROSO
22d. ADDRESS: E.S.S. HOSPITAL, CAMBRIDGE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9-4-67
23c. NAME OF CEMETERY OR CREMATORY: Green Acres Park
23d. LOCATION (City or Town) (County) (State): Salisbury Wies Md.

24. FUNERAL DIRECTOR: Dorothea B. Jolley ADDRESS: Jersey Road Rt #2 Salisbury, Md
25a. REC'D BY REGISTRAR DATE SEP 6 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10963 10963

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: 24 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Cambridge-Maryland Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
d. STREET ADDRESS: 906 Camelia Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Amanda — Middle Shackelford — Last North
4. DATE OF DEATH: Month Aug. — Day 15, — Year 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 2, 1904
9. AGE (If years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homameker
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Fredericks, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Nathaniel Shackelford
14. MOTHER'S MAIDEN NAME: Julia Brooks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 213-12-4961
17. INFORMANT: Paul A. Trigger, Address 906 Camelia Street, Cambridge, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma Lung — INTERVAL BETWEEN ONSET AND DEATH: 6 months
163X
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-31, 1967, to 8-15, 1967, that (I) (we) last saw the deceased alive on 8-15 1967, and that death occurred at 7:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8-21-67
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 17, 1967
23c. NAME OF CEMETERY OR CREMATORY: Green Lawn Cemetery
23d. LOCATION (City, town or county) (State): Cambridge, Md.

24. FUNERAL DIRECTOR: Kenneth R. Thomas
ADDRESS: Cambridge, Md.
25a. REC'D BY REGISTRAR DATE: AUG 25 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10964 — **CERTIFICATE OF DEATH** — 10964

1. **PLACE OF DEATH**
   a. COUNTY: Dorchester — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
   c. LENGTH OF STAY IN 1b: 3 years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): 805 Radiance Dreive

2. **USUAL RESIDENCE** (Where deceosed lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Dorchester
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Toddville 09,1
   d. STREET ADDRESS: None
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First BERTHA — Middle MEREDITH — Last ROBINSON

4. **DATE OF DEATH**: Month Aug. — Day 30 — Year 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 14, 1882

9. AGE (In years last birthday): 85 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Packer

10b. KIND OF BUSINESS OR INDUSTRY: Seafood

11. BIRTHPLACE (County & State, or foreign country): Dorchester Co., Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Meredith

14. MOTHER'S MAIDEN NAME: Mary ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
   (If yes give wor or dotes of service): - - -

16. SOCIAL SECURITY NO.: unk

17. INFORMANT — Address: Mrs Hiram Johnson, Cambridge, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Uremia + Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 1 mo
   DUE TO (b): Hypertension - arteriosclerotic CVRD — ?
   DUE TO (c):
   Conditions, if ony, which gove rise to immediate cause (a), stating the underlying couse lost.
   442 X

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While ot wark ☐ Not While ot wark ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug 1X, 1967 to Aug 30, 1967 thot (I) (we) lost saw the deceased alive an Aug 30 1967, and that death occurred at 1:14 M, fram causes and an the dote stated abave.

22a. SIGNATURE: M Thompson — ATTENDING PHYS. M.D. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/31/67

22c. PHYSICIAN'S NAME (Type): J. U. Thompson, MD

22d. ADDRESS: Cambridge, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept 2 1967

23c. NAME OF CEMETERY OR CREMATORY: Toddville Meth Churchyard

23d. LOCATION (City or Town) (County) (State): Toddville, Maryland

24. FUNERAL DIRECTOR — ADDRESS: LeCompte Funeral Service, Cambridge, Maryland

25a. REC'D BY REGISTRAR: DATE SEP 5 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then pleose remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremotion, or removal, and in any event, within 72 hours of death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10965 10965

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: DORCHESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL CAMBRIDGE
c. LENGTH OF STAY IN 1b: 12 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): EASTERN SHORE STATE HOSPITAL

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): POCOMOKE
d. STREET ADDRESS: 702 MARKET ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Lost	4. DATE OF DEATH Month	Doy	Year
MIN	Pearson	SCHOOLFIELD	AUGUST	24	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In yeors lost birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
FEMALE	WHITE		5/16/92	75 yrs.		

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & Stote, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	--	VIRGINIA	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
THOMAS PEARSON	Nancy Cecil

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give wor or dotes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	--	None	HOSPITAL RECORDS

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) Diffuse peritonitis
DUE TO (b) Incarceration of colon
Conditions, if ony, which gave rise to immediote couse (o), stoting the underlying couse last. DUE TO (c) Carcinoma of asc. colon + adhesions
1530
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19	20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐	20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)	20f. (City or town) (County) (Stote)

21. **I certify** that (I) (this haspital) attended the deceased from JULY 22, 1955, to AUG. 24, 1967, that (I) (we) last saw the deceased alive on AUG. 24 1967, and that death occurred at ____M, from causes and on the date stated above

22o. SIGNATURE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22b. DATE SIGNED
P & W Kiesel M.D., Pathologist				8/24/67

22c. PHYSICIAN'S NAME (Type) P & W. Riecker — 22d. ADDRESS E.S.S.H., CAMBRIDGE, MD.

23o. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY	23d. LOCATION (City or Town) (County) (Stote)
Burial	8-26-1967	Presbyterian	Pocomoke City Wor. Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Robert H. Watson	Pocomoke City, Md.	AUG 28 1967	

Robert H. Watson

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10966 Item #17 Film #0392 976/97 DC 10966

TO HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Dorchester
MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Galestown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Galestown
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EVELYN Middle HASTINGS Last SHORT

4. DATE OF DEATH: Month August Day 4 Year 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: February 4, 1902

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Galestown, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Howard L. Hastings

14. MOTHER'S MAIDEN NAME: Hattie Wheatley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Miss Louise Short Address: Hastings, Galestown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 2-4 mos.

0021
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Diabetes — 8 yrs
DUE TO (c): Asthma — 4 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from ____, 19__ to Aug 4, 1967, that (I) (we) last saw the deceased alive on Aug 4 1967, and that death occurred at 9:55 PM, from the causes and on the date stated above.

22a. SIGNATURE: H.S. Kuhlman M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Aug 5/67

22c. PHYSICIAN'S NAME (Type): H.S. Kuhlman

22d. ADDRESS: Hurlock Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 7, 1967

23c. NAME OF CEMETERY OR CREMATORY: Galestown Cemetery

23d. LOCATION (City, town or county) (State): Galestown, Maryland

24. FUNERAL DIRECTOR: J. J. Frampton and Son

ADDRESS: Federalsburg, Maryland

25a. REC'D BY REGISTRAR DATE: AUG 28 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10967

CERTIFICATE OF DEATH

10967

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Eastern Shore State Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Church Creek — b. COUNTY: Dor.
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Maryland
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Thurman — Middle: M. — Last: Shorter
4. DATE OF DEATH: Month: 8 — Day: 20 — Year: 19 67
5. SEX: M
6. COLOR OR RACE: W.
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 08-20-88
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer-Mechanic
10b. KIND OF BUSINESS OR INDUSTRY: Dirt-Machine
11. BIRTHPLACE (County & State, or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Solomon Shorter
14. MOTHER'S MAIDEN NAME: Q. Ellen ~~Shorter~~ Lawson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: unk
17. INFORMANT: Address: Patient's chart

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Probable massive hypocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: 15 min
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Generalized arteriosclerosis — 1 month
DUE TO
(c):
4201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonitis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 8-5-67, 19__, to 8-20-, 1967 that (I) (~~we~~) last saw the deceased alive on 8-20-67 19__, and that death occurred at 12 1/4 A M, from causes and on the date stated above.

22a. SIGNATURE: E. Lewis — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 8-20-67
22c. PHYSICIAN'S NAME (Type): EDWARD LEWIS, JR
22d. ADDRESS: ESSH, CAMBRIDGE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug 23 1967
23c. NAME OF CEMETERY OR CREMATORY: East New Market Cemetery
23d. LOCATION (City or Town) (County) (State): East New Market, Maryland

24. FUNERAL DIRECTOR: LeCompte Funeral Ser. — ADDRESS: Cambridge, Maryland
25a. REC'D BY REGISTRAR DATE: AUG 22 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10968 10968

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hurlock
c. LENGTH OF STAY IN 1b: 1 hour
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rt. 307

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Florida
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Orlando
d. STREET ADDRESS: 600 block W. Long St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Curtis — Middle: — Last: Simms

4. DATE OF DEATH: Month: August — Day: 23 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Black

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: ?

9. AGE (In years last birthday): 22 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Migrant laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm labor

11. BIRTHPLACE (State or foreign country): Florida ?

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Cambridge Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intracranial injuries — INTERVAL BETWEEN ONSET AND DEATH: Instant
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Two car collision

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 1AM 8/23/67

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town): Hurlock (County): Dor. (State): Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER: John Mace M.D.

EXAMINER'S NAME (Type): John Mace Jr.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

22. DATE SIGNED: 8/23/67

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 8.28.'67

23c. NAME OF CEMETERY OR CREMATORY: U. of Md. Med. School

23d. LOCATION (City or Town): Baltimore (County): (State): Md.

24. FUNERAL DIRECTOR: ADDRESS:

25a. REC'D BY REGISTRAR DATE: AUG 29 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10969 **CERTIFICATE OF DEATH** 10969

1. **PLACE OF DEATH**
   a. COUNTY: Dorchester — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
   c. LENGTH OF STAY IN 1b: 7Hrs. 12 Mins
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Cambridge Maryland Hospital Inc.

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Dorchester
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
   d. STREET ADDRESS: 122 Vue de Leau St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First — Middle — Last: Slacum

4. **DATE OF DEATH**: Month: August — Day: 6 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 6, 1967

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days: 7 — IF UNDER 24 HRS.: Hours: 12 — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): Dorchester-Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Lyn Birtcell Slacum

14. MOTHER'S MAIDEN NAME: Glenda Kay Slacum

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs Glenda Slacum 122 Vuede Leau St. — Address: Cambridge, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Immaturity — INTERVAL BETWEEN ONSET AND DEATH
776X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8-6, 19 67, to 8-6, 19 67, that (I) (we) last saw the deceased alive on 8-6 19 67, and that death occurred at 8:45 P M, from causes and on the date stated above.

22a. SIGNATURE: E. Fernandez M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8-6-67

22c. PHYSICIAN'S NAME (Type): EFRAIN C. FERNANDEZ

22d. ADDRESS: 138 Race St. Cambridge Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 7 AUG '67

23c. NAME OF CEMETERY OR CREMATORY: DORCHESTER MEM. PARK

23d. LOCATION (City or Town) (County) (State): CAMBRIDGE DOR. MD.

24. FUNERAL DIRECTOR: Kenneth R Thomas Jr. — ADDRESS: CAMBRIDGE MD.

25a. REC'D BY REGISTRAR DATE: AUG 9 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10970

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10970

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Dorchester — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Andrews, Dor. Co.
   c. LENGTH OF STAY IN 1b: entire life
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rural

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Dorchester
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
   d. STREET ADDRESS: 1104 Race Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: James — Middle: Wilby — Last: Slacum, Sr.,

4. DATE OF DEATH: Month: Aug. — Day: 25, — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: Nov. 5, 1900

9. AGE (In years last birthday): 66 yrs.
   IF UNDER 1 YEAR: Months: — Days: —
   IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Freight Co. Manager

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Andrews, Dorchester Co.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James D. Slacum

14. MOTHER'S MAIDEN NAME: Fannie Hooper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-07-7718

17. INFORMANT: Mrs. Nettie H. Slacum, Address: 1104 Race Street, Cambridge, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b):
   DUE TO
   (c):
   4201

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

   19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

   20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

   20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

   20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

   20d. INJURY OCCURRED While at work ☐ Not While at work ☐

   20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

   20f. (City or town) (County) (State)

   21. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

   ACTUAL SIGNATURE: John Mace Jr. M.D.
   EXAMINER'S NAME (Type): John Mace Jr. M.D.
   CHIEF MEDICAL EXAMINER ☐
   ASSISTANT MEDICAL EXAMINER ☐
   DEPUTY MEDICAL EXAMINER ☒
   Address (Street, city, town, or county): Cambridge, Md.
   22. DATE SIGNED: 8/27/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 27, 1967
23c. NAME OF CEMETERY OR CREMATORY: Dorchester Memorial Park,
23d. LOCATION (City or Town) (County) (State): Cambridge, Md.

24. FUNERAL DIRECTOR: Kenneth R. Shoreard — ADDRESS: Cambridge, Md.
25a. REC'D BY REGISTRAR — DATE: SEP 1 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10971

CERTIFICATE OF DEATH

10971

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Dorchester
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Cambridge Maryland Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crocheron
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ETTA Middle T. Last SULLENDER

4. DATE OF DEATH: Month Aug. Day 17 Year 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 14, 1877
9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Dorchester Co., Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William H. Todd
14. MOTHER'S MAIDEN NAME: Melvinia Bramble

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No - - -
16. SOCIAL SECURITY NO.: 212-14-4212
17. INFORMANT Address: Mrs McClain Robinson, Crocheron, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Hypertensive Heart Disease — 20 yrs
DUE TO (c): ___
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/14, 1967, to 8/17, 1967, that (I) (we) last saw the deceased alive on 8/17 1967, and that death occurred at 6 05 p.m. from causes and on the date stated above.

22a. SIGNATURE: Lawrence Maryanov M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/18/67
22c. PHYSICIAN'S NAME (Type): Lawrence Maryanov MD
22d. ADDRESS: 610 Race St. Cambridge, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug 20, 1967
23c. NAME OF CEMETERY OR CREMATORY: Dorchester Memorial Park
23d. LOCATION (City or Town) (County) (State): Cambridge, Maryland

24. FUNERAL DIRECTOR ADDRESS: LeCompte Funeral Service, Cambridge, Maryland
25a. REC'D BY REGISTRAR DATE: AUG 22 1967
25b. REGISTRAR'S SIGNATURE: Charles Jones

18 Jan 1

da. 1968

10972

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10972

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hurlock
c. LENGTH OF STAY IN 1b: Cant say
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Buck Andrews Labor Camp

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Florida
b. COUNTY: ?
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ?
d. STREET ADDRESS: ?
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

48-3

3. NAME OF DECEASED (Type or print): First Herman Middle Taylor Last (alias Hank Martin)

4. DATE OF DEATH: Month 8/7/67 Doy Year 19

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Unknown
9. AGE (In years last birthday): About 40
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Migrant Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Migrant Labor
11. BIRTHPLACE (State or foreign country): Unknown
12. CITIZEN OF WHAT COUNTRY? Unknown

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
983X
IMMEDIATE CAUSE (a): Subdural Hemorrhage
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
BXXXX Beaten up by another migrant.
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. ? 8/7/67
20d. INJURY OCCURRED While at work ☐ Not While at work XX
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.): Labor camp
20f. (City or town) Hurlock (County) Dor. (State) Md.

21. I certify that I took charge of the remains described above, held on Autapsy XX Inspectian ☐, Inquiry ☐, and in my apinian deoth resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Hamicide [X], Undetermined manner ☐

ACTUAL SIGNATURE: John Mace Jr. M.D.
EXAMINER'S NAME (Type): John Mace Jr.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county)

22. DATE SIGNED: 8/7/67

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: 8-21-67
23c. NAME OF CEMETERY OR CREMATORY: U. of Md. Med. School
23d. LOCATION (City or Town): Baltimore (County) (State) Md.

24. FUNERAL DIRECTOR — ADDRESS

25a. REC'D BY REGISTRAR DATE AUG 23 1967
25b. REGISTRAR'S SIGNATURE: Charles Juggs

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10973

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10973

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge R.F.D.
c. LENGTH OF STAY IN 1b: All life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): --

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Mary land — b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge, Md. R.F.D. (Bucktown)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First THOMAS Middle Lost — Charlotte Thompson

4. DATE OF DEATH: Month August — Day 1 — Year 19 67

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: 5-1-1872
Age (In years last birthday): 95 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MARTIN LAKE
14. MOTHER'S MAIDEN NAME: MANDY CAMPER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: -
17. INFORMANT — Address: DaRue Pinder, Cambridge, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Corobary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X] Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: John Mace Jr. M.D.
EXAMINER'S NAME (Type): John Mace Jr.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county):
22. DATE SIGNED: 8/4/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/6/67
23c. NAME OF CEMETERY OR CREMATORY: Bucktown
23d. LOCATION (City or Town) (County) (State): Bucktown Dorchester Md

24. FUNERAL DIRECTOR: Hilda L West — ADDRESS: Cambridge

25a. REC'D BY REGISTRAR DATE: AUG 8 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10974 10974

1. PLACE OF DEATH
a. COUNTY Dorchester County
Cambridge-Hospital Md MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge
c. LENGTH OF STAY IN 1b Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hosp

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland b. COUNTY Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge
d. STREET ADDRESS 09.1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Roger Middle Williams Last Thomas
4. DATE OF DEATH Month August Day 24, Year 1967
5. SEX Male
6. COLOR OR RACE Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 1-10-02
9. AGE (In years last birthday) 65 yrs. IF UNDER 1 YEAR Months 7 Days 18 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Work
10b. KIND OF BUSINESS OR INDUSTRY Farm
11. BIRTHPLACE (County & State, or foreign country) Cambridge
12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME John Thomas
14. MOTHER'S MAIDEN NAME Camila Thomas
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 214-07-8963
17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral vascular hemorrhage - Uremia	
442 X Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b)	arteriolosicerotic cardiovascular -	1 week
DUE TO (c)	renal disease	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Sick or Left Taken to Camb Hosp.
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street/office bldg., etc.) Farm
20f. (City or town) Town Point (County) (State) Md

21. I certify that (I) (this hospital) attended the deceased from August 10 1967, to August 21 1967 that (I) (we) last saw the deceased alive on August 21 1967, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED August 24, '67
22c. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.
22d. ADDRESS 623 High Street, Camb., Maryland

23a. BURIAL, CREMATION, ~~REMOVAL (Specify)~~
23b. DATE THEREOF 8/27/67
23c. NAME OF CEMETERY OR CREMATORY Bethel
23d. LOCATION (City, town or county), (State) Cambridge Md

24. FUNERAL DIRECTOR Hilda West ADDRESS Salisbury Md
25a. RECD BY REGISTRAR DATE AUG 29 1967 8/27/67
25b. REGISTRAR'S SIGNATURE Charles Jessie Harry Jessie

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10975 10975

1. PLACE OF DEATH
a. COUNTY Dorchester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge
c. LENGTH OF STAY IN 1b 2 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Md b. COUNTY Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Louis Middle: Thomas Last: Tobat Sn

4. DATE OF DEATH Month: 8 Day: 7 Year: 1967

5. SEX M.

6. COLOR OR RACE White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 7/12/1898

9. AGE (In years last birthday) 69 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman & Carpenter
10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Michael Tobat

14. MOTHER'S MAIDEN NAME Josephine Koswoski

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO. 1533

17. INFORMANT Address Mrs Helen Tobat East New Market

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC CARCINOMA FROM SIGMOID
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-31, 1967, to 8-7, 1967, that (I) (we) last saw the deceased alive on 8-7 1967, and that death occurred at 11:20 A.M., from the causes and on the date stated above.

22a. SIGNATURE James F. McCarter
M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED 8-8-67

22c. PHYSICIAN'S NAME (Type) James F. McCarter, M.D.

22d. ADDRESS 704 LOCUST ST. CAMS, MD. 21613

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE THEREOF 8/10/67

23c. NAME OF CEMETERY OR CREMATORY Our Lady of Good Counsel

23d. LOCATION (City, town or county) (State) Secretary Md.

24. FUNERAL DIRECTOR ADDRESS Ruth S. Tilbury by, East New Market

25a. REC'D BY REGISTRAR DATE AUG 10 1967

25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

[redacted]YLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10976

CERTIFICATE OF DEATH

10976

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
c. LENGTH OF STAY IN 1b: HRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Cambridge-Md. Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pittsville
d. STREET ADDRESS: Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Raymond; Middle: ; Last: White

4. DATE OF DEATH: Month: August; Day: 4; Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/20/1873

9. AGE (In years last birthday): 93 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer - retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Wicomico, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John William White

14. MOTHER'S MAIDEN NAME: Laura Ellen Freeny

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 217-48-2365

17. INFORMANT: Mrs. Laura Wells — Address: Pittsville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Medullary paralysis + Cong Failure — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO (b): Arteio-sclerotic C V D — ?
DUE TO (c): Arterio-sclerosis gen — L

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Anemia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 3, 1967, to Aug 4, 1967 that (I) (we) last saw the deceased alive on Aug 3 1967, and that death occurred at 7:2 M, from the causes and on the date stated above.

22a. SIGNATURE: A.T. Thompson — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/5/67

22c. PHYSICIAN'S NAME (Type): A.T. Thompson

22d. ADDRESS: Cambridge Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/8/67

23c. NAME OF CEMETERY OR CREMATORY: Pittsville Cemetery

23d. LOCATION (City, town or county) (State): Pittsville Md.

24. FUNERAL DIRECTOR: Hill Funeral Home — ADDRESS: Salisbury Md.

25a. REC'D BY REGISTRAR DATE: AUG 9 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10977

CERTIFICATE OF DEATH

10977

1. PLACE OF DEATH
a. COUNTY: Dorchester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge R
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Cambridge Maryland Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Cambridge
d. STREET ADDRESS: RFD No. 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGIA — Middle MARSHALL — Last WINGATE

4. DATE OF DEATH: Month Aug. — Day 30 — Year 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 14, 1878

9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Dorchester Co., Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Eljiah Marshall

14. MOTHER'S MAIDEN NAME: Sallie Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): - - -

16. SOCIAL SECURITY NO.: unk

17. INFORMANT — Address: Mrs. Evelyn Thomas, RFD 3, Cambridge, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ARTERIO SCEROTIC HT. DISEASE — INTERVAL BETWEEN ONSET AND DEATH: 3 WKS
DUE TO
4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/23, 1967, to 8/30, 1967, that (I) (we) last saw the deceased alive on 8/30 1967, and that death occurred at 2:35 PM, from causes and on the date stated above.

22a. SIGNATURE: Alfred R. Maryanov — M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/31/67

22c. PHYSICIAN'S NAME (Type): ALFRED R. MARYANOV

22d. ADDRESS: 610 RACE ST, CAMBRIDGE, Dorch MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept 1 1967

23c. NAME OF CEMETERY OR CREMATORY: Dorchester Memorial Park

23d. LOCATION (City or Town) (County) (State): Cambridge, Maryland

24. FUNERAL DIRECTOR — ADDRESS: LeCompte Funeral Service, Cambridge, Maryland

25a. REC'D BY REGISTRAR — DATE: SEP 5 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10978 Item d Film C391 8/21/67 kk

CERTIFICATE OF DEATH

10978

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 haurs after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
   a. COUNTY: Dorchester — MARYLAND
   b. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest tawp): Cambridge
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address): Cambridge Maryland Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institutian: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Dorchester
   c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest tawn): Vienna
   d. STREET ADDRESS: R.D.
   e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Alma — Middle: — Last: Young

4. **DATE OF DEATH**: Month: 8 — Day: 4 — Year: 1967

5. SEX: F

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-4-1912

9. AGE (In years last birthday): 55 — 378 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Haurs / Min.

10a. USUAL OCCUPATION (Give kind of wark done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (County & State, ar fareign country): Vienna

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: ISSAC Jackson

14. MOTHER'S MAIDEN NAME: Mary Pinkett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknawn) (If yes give war ar dates of service)

16. SOCIAL SECURITY NO.: 219-03-5645

17. **INFORMANT**: James R. Young — Address: Vienna, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter anly one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Abdominal carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 6 mos
   DUE TO
   Conditians, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b): Carcinoma of right ovary — 1 yr(s)
   DUE TO
   (c):

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature af injury in Part I ar Part II af item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Hame, farm, factary, street, office bldg., etc.)

20f. (City ar tawn) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan, 1967 to Aug 4, 1967, that (I) (we) last saw the deceased alive on Aug 4 1967, and that death accurred at 0A M, from causes and an the date stated above.

22a. SIGNATURE: Lewis M. Burdette M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: Aug 8, 1967

22c. PHYSICIAN'S NAME (Type): Lewis M. Burdette — 22d. ADDRESS: 4 Aurora St. Cambridge, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 8-7-67 — 23c. NAME OF CEMETERY OR CREMATORY: Salem — 23d. LOCATION (City ar Tawn) (County) (State): Salem Dorc. Md.

24. FUNERAL DIRECTOR: Fontie B. Jolley — ADDRESS: Salisbury, Md.

25a. REC'D BY REGISTRAR DATE AUG 14 1967 — 25b. REGISTRAR'S SIGNATURE: Charles Judge